

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

NEUROLOGICAL SURGERY
ASSOCIATES, P.A. a/s/o D.O.,
Plaintiffs(s),
v.

AETNA LIFE INSURANCE COMPANY;
LABORERS LOCAL 754 JOINT
BENEFIT FUNDS; ABC CORP. (1-10)
(Said names being fictitious and unknown
entities),

Defendant(s),

Civil Action No.: 2:12-cv-5600

CIVIL ACTION

**CERTIFICATION OF ANDREW R.
BRONSNICK IN OPPOSITION TO MOTION
FOR SUMMARY JUDGMENT**

I, ANDREW R. BRONSNICK, do hereby certify as follows:

1. I am an attorney at law of the State of New Jersey, partner with the Law Firm of Massood & Bronsnick, LLC, attorneys for the Plaintiff, Neurological Surgery Associates, P.A. a/s/o D.O. This Certification is submitted in opposition to Defendant's Motion for Summary Judgment.
2. Annexed hereto as **Exhibit "A"** is a true copy of the original Operative Report for the date of service April 8, 2011 with redactions of D.O.'s identity.
3. Annexed hereto as **Exhibit "B"** is a true copy of the original 2013 Optum Neurosurgery/Neurology Coding Companion pages 285 and 287.
4. Annexed hereto as **Exhibit "C"** is a true copy of the original Assignment of Benefits executed by D.O.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

MASSOOD & BRONSNICK, LLC
Attorney for Plaintiff



By: _____
ANDREW R. BRONSNICK

Dated: December 2, 2013

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EXHIBIT “A”

ST. MARY'S HOSPITAL
350 Boulevard Passaic NJ 07055
Tel: (973)-365-4300; Fax (973)-365-4546

OPERATIVE REPORT

Patient Name: [REDACTED]

Medical Record #: 100165496

Account #: 900810038

Date of Admission: April 8, 2011

Date of Operation: April 8, 2011

Surgeon: John Cifelli, M.D.

Assistant: Sarah Bodie

Preoperative Diagnoses:

- 1. L5-S1 herniated disc, ICD-9 #722.10.
- 2. Low back pain, ICD-9 #724.2.
- 3. Lumbar radiculopathy, ICD-9 #724.4.
- 4. Lumbar spinal stenosis, ICD-9 #724.02.

Postoperative Diagnoses:

Same.

Operations:

- 1. Bilateral L5 laminectomy, facetectomy, and foraminotomy with decompression of nerve roots, CPT #63047.
- 2. Left S1 lateral recess decompression and foraminotomy with decompression of nerve root, CPT #63048.
- 3. Open L5-S1 discectomy, CPT #63030-59.
- 4. Left L5-S1 posterior lumbar interbody arthrodesis, CPT #22630.
- 5. Right L5-S1 posterior lumbar interbody arthrodesis, CPT #22630-50.
- 6. Application of right L5-S1 intervertebral PEEK cage, CPT #22851.
- 7. Application of left L5-S1 intervertebral PEEK cage, CPT #22851.
- 8. L5-S1 posterior nonsegmental instrumentation, CPT #22840.
- 9. Harvesting of local bone autograft, CPT #20938.
- 10. Placement of Novabone, CPT #20930.
- 11. Use of microscope for microdissection, CPT #69990.
- 12. Fluoroscopic guidance for localization, CPT #77002-26.
- 13. Bone marrow aspiration, CPT #38220.

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Page#1

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14. Harvesting of fat grafts, CPT #20926.
15. Placement of right On-Q local anesthetic catheter, CPT #22899-59.
16. Placement of left On-Q local anesthetic catheter, CPT #22899-59.
17. L5-S1 posterolateral arthrodesis, CPT #22612.
18. Harvesting of morselized left posterior iliac crest autograft, CPT #20937.
19. Bone marrow harvesting for transplantation, CPT #38230.

Anesthesia: General endotracheal.
Anesthesiologist:
Estimated Blood Loss: Approximately 350 mL.
Drains: Medium size Hemovac
Condition: Stable, transferred to the recovery room.
Complications: None.
Position: Prone.
Specimen: L5-S1 disc

BRIEF CLINICAL HISTORY:

INDICATIONS FOR SURGERY:
[REDACTED] is a [REDACTED] with complaints of severe and intractable low back pain since she was a pedestrian struck by a motor vehicle back on August 4, 2009. She experiences constant pain across her lumbosacral spine, which intermittently radiates into her left buttock and down the back of her left leg. Her low back pain is much more severe than her radiating left leg pain. On neurologic examination, she has weakness of her left ankle dorsiflexion, EHL and gastrocnemius muscles at 4/5 and she has diminished sensation to both pinprick and light touch over her entire left foot most significantly over her lateral foot, great toe and sole. The MRI of her lumbar spine revealed a recurrent/residual central and left-sided L5-S1 disc herniation narrowing the left lateral recess and contributing to left L5 neuroforaminal stenosis. The L5-S1 disc has diminished height and is hypointense. She is now brought to the operating room for a L5-S1 decompression and fixation/fusion procedure with instrumentation in hopes of relieving her pain and preventing further neurologic injury. No guarantees were made in any way and informed consent was obtained prior to surgery.

Page#2

Patient Name: [REDACTED]
April 8, 2011
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FINDINGS:

Stenosis was present at the L5-S1 level therefore bilateral inferior L5 hemilaminectomies were completed for decompression. The boundaries of the previous left L5 laminotomy were identified and enlarged. Significant bilateral neuroforaminal stenosis was found at the L5 level and therefore extensive foraminotomies were completed for decompression. The left S1 nerve root was found to be compressed within its lateral recess and therefore an extensive left S1 lateral recess decompression and foraminotomy for bony stenosis was completed for decompression. A central and left paracentral L5-S1 residual or recurrent disc herniation was found compressing the ventral aspect of the thecal sac and left S1 nerve root at its exit and therefore a L5-S1 discectomy was necessary and completed for decompression. The amount of bone removed for the hemilaminectomies, foraminotomies and lateral recess decompression was more extensive and time consuming than usually required for a routine posterior lumbar interbody arthrodesis and fusion procedure. Additionally the amount of disc required to be removed for decompression was also more than usually required for a routine posterior lumbar interbody arthrodesis and fusion procedure. From both right and left-sided approaches, a bilateral posterior lumbar interbody arthrodesis was completed at the L5-S1 level. The L5-S1 disc space was found to have diminished height and two Reliance PEEK cages, one on the right and one on the left, each measuring 10 mm in width x 28 mm in length x 6 mm in height were placed at the L5-S1 level. A posterior nonsegmental instrumentation at L5-S1 was completed using 4 S-Lok screws measuring 8.5 x 40 mm at the L5 level and 7.5 x 30 mm at the S1 level and secured using a 5.5 x 45 mm S-Lok rod on the right side and a 5.5 x 40 mm S-Lok rod on the left side. The PEEK cages were filled with local bone, which was harvested from the lamina using Kerrison and Leksell rongeurs, Novabone, and left posterior iliac crest morcellized autograft. A posterolateral arthrodesis was completed bilaterally at the L5-S1 level using the Midas Rex high-speed electric drill to decorticate the facet joints, L5 transverse processes and ala of the sacrum. A microscope was used to help aid in microdissection and to help complete the discectomy. There was a large amount of epidural fibrosis present which was tethering the left S1 nerve root and the microscope was necessary to help aid in the microdissection and neurolysis. Following the neurolysis, the nerve root was relatively free and mobile. The remaining local bone, posterior iliac crest autograft, and Novabone was placed posterolaterally for fusion. It was soaked in 10 mL of bone marrow, which was harvested from the left posterior iliac crest using a Jamshidi needle. Bone marrow was also aspirated from the vertebral bodies and placed posterolaterally for fusion. Two subcutaneous fat grafts were harvested and placed along the S1 nerve roots bilaterally in an epidural fashion. Two 5-inch right and left On-Q local anesthetic catheters were placed parallel to the incision at entry points approximately 2 inches superiorly and laterally to the incision to help treat postoperative pain and reduce the amount of pain medications required. Sarah Bodie assisted for the entire procedure, which is usual and customary for this type of surgery. I personally supervised and interpreted the intraoperative fluoroscopic imaging, which confirmed proper placement of the pedicle screws and interbody cage devices.

OPERATIVE PROCEDURE:

After previously obtaining informed consent and discussion of possible risks, benefits, and alternatives of the procedure in a detailed way and after having made no guarantees in any way, the patient was brought to the operating room on a stretcher at which time general endotracheal anesthesia was induced without complications.

Patient Name: [REDACTED]
April 3, 2011
S 0408-164 8942 2011 00

Page#3

DCN: 110418122365 SEQ: 0418110037 EP

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The patient was then turned on to the Wilson frame of the operating table in the prone position with her arms raised above her head less than 90 degrees at both the shoulder and elbow joints. 1 g of vancomycin was infused. Baseline electrophysiologic recordings were then obtained and were found to be within normal limits and unchanged at the conclusion of the procedure. The patient's low back and iliac crest were then shaved, prepped and draped in the usual sterile fashion.

After first infiltrating with local anesthesia, a midline skin incision approximately 3 inches in length was made extending from the L4 to S1 spinous processes. The incision incorporated the previous scar from her microdiscectomy. The incision was carried down through the subcutaneous tissue and fat to the lumbar fascia, which was incised along each side of the spinous processes and the deep paraspinal musculature on each side was then elevated in a subperiosteal-type fashion and retained laterally. A localizing fluoroscopic x-ray was then obtained. The exposure continued laterally at the L5-S1 level to expose the facet joints, L5 transverse processes and sacral ala. The spinous processes and interspinous ligaments were kept intact. The borders of the previous left L5 laminotomy were identified and extended to include a near complete left L5 hemilaminectomy. The remaining yellow ligament was also carefully removed without any injury to the underlying dura or neural elements. A similar right L5 hemilaminectomy was also completed without any difficulty. A Woodson elevator was then passed along the L5 nerve roots bilaterally with difficulty due to stenosis and therefore extensive bilateral L5 foraminotomies were completed for decompression. A left S1 lateral recess decompression and foraminotomy was also completed for decompression. The microscope was then brought into the operative field and a neurolysis was completed of the left S1 nerve root and left side of the thecal sac. With gentle retraction of the left S1 nerve root medially, which was found to be displaced posteriorly and inflamed, a central and left paracentral L5-S1 disc herniation was identified. An annulotomy was made, followed by removal of the herniated portions of the disc with good decompression of the thecal sac and S1 nerve root. Following the hemilaminectomies, foraminotomies, lateral recess decompression and discectomy the neural elements were fully decompressed. From a right-sided approach, a right L5-S1 posterior lumbar interbody arthrodesis was completed using a 6 mm rotating cutter. From a left-sided approach, a similar posterior lumbar interbody arthrodesis was completed. The amount of bone removed at the L5 and S1 levels was very extensive and therefore bilateral PLIF procedures were necessary including placement of two PEEK cages to help prevent potential postoperative instability. A small incision was made over the left superior posterior iliac crest point and a total of 10 mL of bone marrow was harvested from deep within the iliac crest using a Jamshid needle. Morselized posterior iliac crest autograft was also harvested. The bone, which was harvested from the lamina was denuded of soft tissue and placed within the PEEK cages along with the posterior iliac crest bone marrow, autograft and Novabone. The PEEK cages were then placed on both the right and left sides at the L5-S1 level without any difficulty and under direct fluoroscopic guidance. They were countersunk several millimeters. Four pedicle screws of the above mentioned sizes were then placed at the L5-S1 level without any difficulty. Pilot holes were first made at the pedicle entry points, followed by use of the pedicle finder. Each hole was carefully probed to check for any cortical defects and there were none at any level. Each screw was stimulated and found to be above acceptable levels.

Patient Name: [REDACTED]
 April 3, 2011
 S 0408-164 8942 2011 00

Page#4

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 DCN: 110418122365 SEQ: 0418110037 EP

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The screws were secured using two prebent lordotic rods and four closure tops, which were final tightened. The L5-S1 facet joints, L5 transverse processes and sacral ala were then decorticated for arthrodesis using the Midas Rex drill and the remaining bone was placed posterolaterally along with Novabone which was soaked in bone marrow, which was aspirated using an Angiocath needle from the vertebral bodies from drilled holes and bone marrow which was harvested from the left posterior iliac crest. A final AP and lateral projection fluoroscopic x-ray was obtained and saved. The wound was then copiously irrigated using 3 liters of Neosporin antibiotic solution and after obtained meticulous hemostasis, a medium size Hemovac drain was placed in the epidural space and the lumbar fascia was reapproximated using interrupted figure-of-eight #1 Vicryl sutures. The subcutaneous tissue was reapproximated using inverted interrupted 2-0 Vicryl sutures and the skin was closed using staples. Two subcutaneous fat grafts were harvested prior to closure and placed along the S1 nerve roots epidurally. The bone was then washed and two 5 inch On-Q local anesthetic catheters were placed along each side of the incision entering approximately 2 inches superiorly and laterally to the incision within the subcutaneous fat. The catheters were secured to the skin using Steri-Strips and a clean sterile dressing was applied to the wound. No bolus dose was given and the On-Q pain pump was filled with 0.375% Marcaine. The patient was then turned back over onto the stretcher in the supine position at which time, she was extubated and transported to the recovery room in stable condition. There were no complications during this procedure and the patient tolerated the procedure well. All sponge counts and needle counts were correct at the end of the procedure and the estimated blood loss was approximately 350 mL.



John Cifelli, M.D.

DD: 04/08/2011 12:32:12 PM
OT: 04/08/2011 02:32:12 PM

Patient Name: [REDACTED]
April 8, 2011
S 0408-164 8942 2011 00

Page#6

DCN: 110418122365 SEQ: 0418110037 EP

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EXHIBIT “B”



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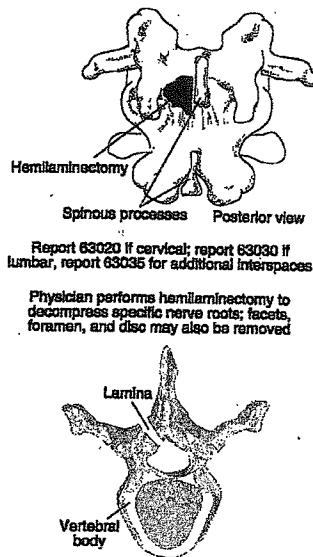
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63020-63035

63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

63030 1 interspace, lumbar

63035 each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)



Explanation

In one method, a midline incision is made through a posterior (back) approach overlying the vertebrae. The incision is carried down through the tissue to the paravertebral muscles, which are retracted. The ligamentum flavum, which attaches the lamina from one vertebra to the lamina of another, may be partially or completely removed. Part of the lamina is removed on one side to allow access to the spinal cord. If a disc has ruptured, fragments or the part of the disc compressing the nerves are removed. A partial removal of a facet (facetectomy) or removal of bone around the foramen (foraminotomy) may also be performed to relieve pressure on the nerve. When decompression is complete, a free-fat graft may be placed to protect the nerve root. If the ligamentum flavum was not removed, it is placed over the fat graft. Paravertebral muscles are repositioned and the tissue is closed in layers. Note that approaches represented by these codes may be open as described above or endoscopically assisted, which still requires open and direct visualization. In an endoscopically assisted approach, a small guide probe is inserted under fluoroscopic guidance. Using magnified

video, as well as fluoroscopic guidance, the endoscope is manipulated through the foramen and into the spinal canal. Once the guide probe has been advanced to the surgical site, a slightly larger tube is manipulated over the guide probe. Surgical instruments are advanced through the hollow center of the tube. Herniated disc fragments are removed, and the disc is reconfigured to eliminate pressure on the nerve root(s). The endoscope is withdrawn. The incision is sutured or simply dressed with an adhesive bandage. Report 63020 if the disc is cervical; 63030 if lumbar; and 63035 for additional interspaces, cervical or lumbar.

Coding Tips

As an "add-on" code, 63035 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. Use 63035 in conjunction with 63020-63030. Arthrodesis is reported separately, see 22590-22632. For re-exploration laminotomy, with partial facetectomy, foraminotomy, and/or excision of the herniated intervertebral disc, see 63040-63044. For laminectomy (complete excision of the lamina), unilateral or bilateral, with facetectomy and foraminotomy, see 63045-63048. For laminectomy performed on one or two vertebral segments, without facetectomy, foraminotomy, or excision of the herniated lumbar disc, see 63001-63011. Hemilaminectomy codes are unilateral by definition. If performed on both sides of the spine (bilaterally), append modifier 50. For a percutaneous endoscopic approach, see 0274T-0275T.

ICD-9-CM Procedural

03.09 Other exploration and decompression of spinal canal

80.51 Excision of intervertebral disc

Anesthesia

63020 00600, 00604, 00670

63030 00630, 00670

63035 N/A

ICD-9-CM Diagnostic

721.0 Cervical spondylosis without myelopathy

721.1 Cervical spondylosis with myelopathy

721.42 Spondylosis with myelopathy, lumbar region

722.0 Displacement of cervical intervertebral disc without myelopathy

722.10 Displacement of lumbar intervertebral disc without myelopathy

722.52 Degeneration of lumbar or lumbosacral intervertebral disc

722.73 Intervertebral lumbar disc disorder with myelopathy, lumbar region

CCI Version 18.3

38220, 38230, 92585, 95822, 95860-95861, 95867-95868, 95900, 95904, 95920, 95936-95939

Also not with 63020: 0213T, 0216T, 0228T, 0230T, 0274T, 12001-12007, 12011-12057, 13100-13153, 20251, 20926, 22100, 22102, 22505, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 61783, 62291, 62310-62319, 63042◊, 63707, 63709, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 64722, 69990, 72285, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 63030: 0171T◊, 0202T, 0213T, 0216T, 0228T, 0230T, 0275T, 12001-12007, 12011-12057, 13100-13153, 20251, 20926, 22102, 22505, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 61783, 62267◊, 62284, 62290, 62310-62319, 63042◊, 63707, 63709, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 64722, 69990, 72295, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 63035: 22100, 95925-95927, 95930-95934

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac	Non-Fac	Status	
	RVU	RVU		
63020	34.83	34.83	90	A
63030	28.79	28.79	90	A
63035	5.66	5.66	N/A	A
	MUE		Modifiers	
63020	1	51	50	62 80
63030	1	51	50	62 80
63035	6	N/A	50	62 80

* with documentation

Medicare References: None

63045-63048

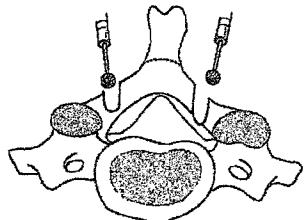
63045 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical

63046 thoracic

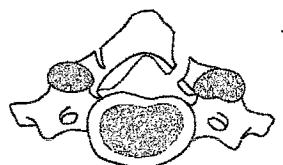
63047 lumbar

63048 each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

Report 63045 if cervical; report 63046 if thoracic; report 63047 if lumbar; report 63048 for each additional segment



To relieve stenosis, the physician trims the facets and cuts the cervical lamina free with burr and chisels



With some techniques the lamina remains partially connected and "floats" on the dura

Explanation

The patient is face down. Magnification may be used during the procedure. The physician makes a midline incision overlying the affected vertebrae. Fascia is incised. Paravertebral muscles are retracted. The physician removes the spinous processes with ronguers. If the stenosis is central, the physician removes the lamina out to the articular facets using a burr. If the compression is in the lateral recess, only half of the lamina is removed. A Penfield elevator peels the ligamentum flavum away from the dura. Nerve root canals are freed by additional resection of the facet, and compression is relieved by removal of any bony or tissue overgrowth around the foramen. Removal of the lamina, facets, and bony tissue or overgrowths may be performed bilaterally when indicated. The ronguer, retractor, and microscope are removed. A free-fat graft may be placed over the nerve root(s) for protection. If the ligamentum flavum was spared, it is placed over the free-fat graft. Paravertebral muscles are repositioned and the deeper tissues and skin are closed with layered sutures. Report 63046 if the procedure

Document 19-1 Filed 12/02/13

affects a thoracic vertebra; report 63047 if the procedure affects a lumbar vertebra; and 63048 for procedures affecting each additional vertebra.

Coding Tips

As an "add-on" code, 63048 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. Use 63048 in conjunction with 63045-63047. Arthrodesis is reported separately; see 22590-22614.

ICD-9-CM Procedural

03.09 Other exploration and decompression of spinal canal

Anesthesia

63045 00600, 00670
63046 00620, 00670
63047 00630, 00670
63048 N/A

ICD-9-CM Diagnostic

721.0 Cervical spondylosis without myelopathy
 721.1 Cervical spondylosis with myelopathy
 721.2 Thoracic spondylosis without myelopathy
 721.42 Spondylosis with myelopathy, lumbar region
 722.10 Displacement of lumbar intervertebral disc without myelopathy
 722.71 Intervertebral cervical disc disorder with myelopathy, cervical region
 722.73 Intervertebral lumbar disc disorder with myelopathy, lumbar region
 723.0 Spinal stenosis in cervical region
 805.3 Open fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
 839.31 Open dislocation, thoracic vertebra

CCI Version 18.3

38220, 38230, 92585, 95822, 95860-95861, 95867-95868, 95900, 95904, 95920, 95936-95939

Also not with 63045: 0213T, 0216T, 0228T, 0230T, 0274T, 12001-12007, 12011-12057, 13100-13153, 20660, 20926, 22100, 22505, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 61783, 62310-62319, 63015♦, 63017-63020, 63040♦, 63046, 63707, 63709, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Page 12 of 14 PageID: 300

64490, 64493, 64505-64530, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 63046: 0213T, 0216T, 0228T, 0230T, 12001-12007, 12011-12057, 13100-13153, 20926, 22102, 22325, 22505, 22852, 32100, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 61783, 62284, 62310-62319, 63005♦, 63012-63015♦, 63017-63020, 63030, 63042, 63707, 63709-63710, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 64722, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 63047: 0171T♦, 0202T, 0213T, 0216T, 0228T, 0230T, 0274T-0275T, 12001-12007, 12011-12057, 13100-13153, 20926, 22102, 22325, 22505, 22852, 32100, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 61783, 62284, 62310-62319, 63005♦, 63012-63015♦, 63017-63020, 63030, 63042, 63707, 63709-63710, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 64722, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 63048: 95925-95927, 95930-95934

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac	Non-Fac	Status
	RVU	RVU	
63045	37.89	37.89	90 A
63046	36.03	36.03	90 A
63047	32.87	32.87	90 A
63048	6.27	6.27	N/A A

MUE

		Modifiers
63045	1	51 N/A 62 80
63046	1	51 N/A 62 80
63047	1	51 N/A 62 80
63048	9	N/A N/A 62 80

* with documentation

Medicare References: None

EXHIBIT “C”

Neurological Surgery Associates, PA
John R. Cifelli, M.D.
1054 Clifton Avenue, Clifton, NJ 07013
1-800-US HEALTH
973-808-5836 (Fax)

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

Name of Insured Print: D [REDACTED]

Social Security Number: [REDACTED]

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

As medical provider I agree to comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that the attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostics centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report of information regarding my physical condition.

Date: 2-18-11


Patient's Signature